

## Bureau of Licensure and Certification

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|---|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>NVS2858HIC</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/24/2008</b> |
|---|--|--|--|

NAME OF PROVIDER OR SUPPLIER

**ALMOST HOME GROUP CARE**

STREET ADDRESS, CITY, STATE, ZIP CODE

**639 N ORLEANS ST  
HENDERSON, NV 89015**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETE<br>DATE |
|--------------------------|--|---------------------|--|--------------------------|
| H 000                    | <p>Initial Comment</p> <p>This Statement of Deficiencies was generated as a result of a state licensure survey and complaint investigation conducted in your facility on 10-24-08.</p> <p>This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999.</p> <p>The census at the time of the survey was two.</p> <p>There was one complaint investigated: Complaint NV00012300 was substantiated without deficiencies.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The following regulatory deficiencies were identified.</p> | H 000               | <p><i>Acceptable Plan</i><br/><i>11/11/09 [Signature]</i></p>  |                          |
| H 019                    | <p>Director Duties-Qualified Caregiver</p> <p>NAC 449.15523 Director: Duties. (NRS 449.249)<br/>The director of a home shall:</p> <p>4. Ensure that a caregiver, who is capable of meeting the needs of the residents and has been trained in first aid, and cardiopulmonary resuscitation, is on the premises of the home at all times when a resident is present.</p> <p>This Regulation is not met as evidenced by:<br/>Based on staff interview and record review, the director failed to ensure that 2 of 3 caregivers had</p>  | H 019               | <p><i>H019</i></p> <p><i>Ⓐ Employee #2 has been enrolled in a FIRST AID &amp; CPR CLASS with CPR connections to be held on 1-21-09</i></p> <p><i>Employee #3 has been enrolled in a FIRST AID AND CPR class with CPR connections to be held on 2-11-09</i></p> |                          |

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LAS VEGAS, NEVADA

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

*Sharon Kay Leppingerweel*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

*Director / owner*

(X6) DATE

*1-11-09*

Bureau of Licensure and Certification

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>NVS2858HIC          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   | (X3) DATE SURVEY<br>COMPLETED<br><br>10/24/2008 |
| NAME OF PROVIDER OR SUPPLIER<br><br>ALMOST HOME GROUP CARE |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>639 N ORLEANS ST<br>HENDERSON, NV 89015 |  |   |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETE<br>DATE                        |
| H 019  | Continued From page 1<br><br>received training in cardiopulmonary resuscitation<br>(CPR) and first aid (Employee #2 and #3).<br><br>Findings include:<br><br>1. Employee #2 began working in 1999. The<br>employee file did not contain documented<br>evidence of a current CPR and first aid<br>certification.<br><br>Employee #2 revealed he had let his CPR and<br>first aid card expire.<br><br>2. Employee #3 began working in 2004. The<br>employee file did not contain documented<br>evidence of a current CPR and first aid<br>certification.<br><br>On 10/28/08 at 8:00am, telephone interview with<br>the Administrator revealed Employee #3 had a<br>recent CPR and first aid card and was attempting<br>to receive a copy from her place of business. | H 019  | H019<br><br>③ ALL Employee Files will<br>be reviewed every 6 months<br>to ensure employees have<br>current First Aid and CPR<br>CARDS on File<br>A Personnel File check list<br>(Attachment #1) will be<br>used to determine if<br>re-certifications ARE due.<br>Employees will be enrolled<br>in re-certification classes<br>prior to expiration dates.<br>The administrator will<br>monitor for compliance.<br><br>② 2/15/09 |   |

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If continuation sheet 2 of 2